DOCUMENT RESUME

ED 381 712 CG 026 188

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TITLE Issues in Student Suicide and Sudden Death Postvention: Best Practices in School Crisis Response.

PUB DATE 11 Nov 94

NOTE 9p.; Paper presented at the Annual Meeting of the Mid-South Educational Research Association (Nashville, TN, November 9-11, 1994).

PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.

DESCRIPTORS *Adolescents; Crisis Intervention; Educational Environment; High Risk Students; Intervention; Prevention; *School Policy; School Responsibility; *School Role; Secondary Education; Student Reaction; *Suicide

IDENTIFIERS *Crisis Management; *Postvention; Suicide Prevention; Suicide Prevention Programs

ABSTRACT

Recent statistics indicate that a high school of 2000 students will experience an average of one student suicide every four years. This paper reviews and synthesizes relevant information on issues in school response to student suicide and sudden death. Highlighted are risk factors that school personnel can identify in suicide-prone students, prevention, intervention, postvention, and ways to avoid common mistakes. Student suicides and sudden deaths often influence student and staff morale, affect student achievement, and may even lead to "copy-cat" suicide attempts by other students. Even schools that have crisis plans that address student suicide and sudden death may not be fully prepared to respond in ways that address all relevant complications. The literature indicates that many school crisis plans do not address such concerns as how students are to be informed of the death, who should speak to the media, what sort of student and staff displays of grief are encouraged, what displays may over-glorify death and suicide, and how counseling and suicide awareness may be used as effective postvention. Schools that have developed and practiced a crisis plan that addresses such issues will be better prepared to deal effectively and efficiently with school crises. (RJM)

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ED 381 712

ISSUES IN STUDENT SUICIDE AND SUDDEN DEATH POSTVENTION: BEST PRACTICES IN SCHOOL CRISIS RESPONSE

PRESENTED AT THE MEETING OF THE MID-SOUTH EDUCATIONAL RESEARCH ASSOCIATION

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NOVEMBER 11, 1994

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ISSUES IN STUDENT SUICIDE AND SUDDEN DEATH POSTVENTION: BEST PRACTICES IN SCHOOL CRISIS RESPONSE

The purpose of this paper is to review and synthesize relevant information on issues in school response to student suicide and sudden death. Recent statistics indicate that a high school of 2000 students will experience an average of one student suicide every four years. Student suicides and sudden deaths often influence student and staff morale, effect student achievement, and may even lead to "copy-cat" suicide attempts by other students. Some schools have developed school crisis plans that address student suicide and sudden death, yet many have not. Even schools that have such plans may not be fully prepared to respond in ways that address all relevant complications of student suicide and sudden death.

The literature indicated that many school crisis plans do not address such concerns as how students are to be informed of the death, who should speak to the media, what sort of student and staff displays of grief are encouraged and what displays may over-glorify death and suicide, and how counseling and suicide awareness may be used as effective postvention. Schools that have developed and practiced a crisis plan that addresses such issues will be better prepared to deal effectively and efficiently with school crises.

ISSUES IN STUDENT SUICIDE AND SUDDEN DEATH POSTVENTION: BEST PRACTICES IN SCHOOL CRISIS RESPONSE

The National Center for Health Statistics reports that over 5000 American teenagers committed suicide in 1986 (Vidal, 1989). This figure places suicide as the second leading cause of death among American teenagers. The leading cause of death among members of this age group is accidents. Many of these "accidental" deaths involve firearms, substance usage, and single automobile accidents, which may, in actuality, be suicidal and misnamed accidents (Poland, 1990). The Suicide Prevention Center of Los Angeles has estimated that 50% of all youth deaths reported as accidents may actually be suicides (Stefanowski-Harding, 1990). As a result, it has been speculated that youth suicide rates may actually be five times the reported rate, giving us the possibility of 2500 American adolescents committing suicide each year (Poland, 1990).

In a review of the literature on youth suicide, Davis (cited in Poland, 1990) commented:

> [I]n spite of a generally low rate of completions, given a high school population of 2000 children, it is predicted [that] a school psychologist could expect suicidal ideation in perhaps as high as 25 to 30% of the student body, suicide attempts by as many [as] 50 students each year, and about one successful suicide every four years. (p.7)

Other estimates of prevalence are roughly equal to what Davis reports. However many researchers note that estimates may actually understate the problem as many suicides may be reported as accidents.

Vidal (1989) indicates that 500,000 young people attempt suicide each year in America. Of these 500,000, approximately 5000 succeed. Furthermore, evidence supports that youth suicide is attempted once every minute. Truly, statistics such as these should alert all to the magnitude of youth suicide.

Surveys of school children have indicated that 10-15% of American school-aged children have attempted suicide. Estimates claim that there may be 50-100 attempts per successful completion. Further estimates reveal that girls attempt suicide about nine times more frequently than boys; however, boys are successful about five times more frequently than girls. It is assumed that this discrepancy may be due to the fact that boys tend to use more violent methods, such as guns and hanging, than girls (Kalafat, 1990).

Risk Factors

Several possible risk factors exist that may help to clue school personnel of the possibility for suicidal behavior. One of the prime risk factors is a sense of loss or threatened loss through death, divorce, or desertion. Other factors include parental rejection, child abuse, and a suicidal parent (Stefanowski-Harding, 1990). Some data indicate that certain characteristics seem more common among suicide victims than among the general adolescent population. These include substance abuse, impulsivity and aggression, depression, learning disorders, anxiety or perfectionism, a family history of suicide, and previous suicide attempts (Kalafat, 1990). Some evidence also suggests that gifted children may also be at risk (Weisse, 1990).

According to Dempsey (1986), two of the most prevalent causes of adolescent suicide are depression and the loss of a parent. Depression is the most commonly felt emotion among suicidal teenagers; however, many teachers and parents misconstrue childhood depression as being normal phases in adolescent growth. Symptoms of childhood depression include a sense of failure, despair, low self-esteem, fatigue and a loss of energy; however, children may often exhibit irritability and aggressiveness also (American Psychiatric Association, 1987). A loss of a parent has been found to be internalized as a sense of rejection in many children. Many adolescents may build this rejection into a sense of guilt as they internalize their sense of loss (Dempsey, 1986).

Many "red flag" symptoms precipitate youth suicide, and school personnel and parents need to be aware of these signals. The American Academy of Child and Adolescent Psychiatry (1991) list ten such symptoms.

(1) Change in eating and sleeping habits.
(2) Withdrawal from friends, family, and regular activities.
(3) Violent actions, rebellious behavior, or running away.
(4) Drug and alcohol use.
(5) Unusual neglect of personal appearance.
(6) Marked personality changes.
(7) Persistent boredom, difficulty concentrating, or declining school work.
(8) Frequent somatic complaints.
(9) Loss of interest in pleasurable activities.
(10) Not tolerating praise or rewards.

A teenager who is planning to commit suicide may also:

(1) Complain of being "rotten" inside.
(2) Give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," "I won't see you again."
(3) Put his or her affairs in order -- for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
(4) Become suddenly cheerful after a period of depression.

There exists three ways that a schools may respond to the need for reducing suicide in school-aged children: prevention efforts to reduce the number of attempted suicides, intervention to keep children who are considering suicide from attempting, and postvention to help the survivors of a completed peer suicide. The basic tenets of these three concepts are presented below.

Prevention

Leenaars and Wenckstern (1991) refer to primary prevention of suicide in the schools as being three phased. First, schools need to provide a structured environment for children to develop intellectually, socially, emotionally, and physically. Most schools provide this for students quite well. The importance of activities where students can succeed and participate cannot be overemphasized. Second, programs that address the

child's affective-emotional development are also important. The curriculum must minimize stress and anxiety placed on students and help students to interact effectively. Resources such as counseling, psychological services, and school health also need to be available and effective in meeting students' needs. Third, suicide awareness and education programs should exist. These programs should help to educate students and faculty about the symptoms associated with suicide and the available resources for help and intervention. A crisis plan should also be included.

Intervention

Interventions can be seen as occurring in two distinct phases. The first phase is known as the acute stage. In this stage the child is viewed as being in crisis. The first goal of this stage is to assess the lethality of the threat. This can be done by asking the child about his or her suicide plan. The more detailed and lethal the plan is the more seriously it should be taken. A very detailed plan involving a child shooting himself with his father's gun at 2:00 AM in a field is much more serious a threat than taking a handful of aspirin at 5:00 PM when the parents are due home. Possible referral decisions are made in this phase. The second phase is the long-term treatment phase. The professional must assess the family dynamics and determine the nature of the child's psychopathology. Both family therapy and individual psychotherapy may be needed and both should last at least three months to be safe. No clear empirical research suggests the desirability of one form of psychotherapy over another.

Postvention

A suicide can have a dramatic effect on families, schools, and communities. Emotions often run high, and a chaotic environment may take over. In the aftermath of a suicide, decisions can be hard to make, and a lack of direction may be evident. Therefore, the need for a crisis plan prior to a suicide cannot be overstated.

A literature search of the entire ERIC educational research data base and the PsychLit psychological base show a number of articles about suicide postvention in the schools. Only a few of these articles describe actual crisis plans. After compiling a list of the recommendations for postvention presented in these plans, it was obvious that crisis plans differ widely in terms of scope and focus. All plans indicated a need to provide counseling to those who grieved. However, only a few indicated who should provide that counseling: school personnel or outside consultants. Many did not address who should speak to the media and what should be said. Most did not address what types of student displays of student grief should be encouraged and what types should not be encouraged. Very few address such issues as systematic screening of students for suicide risk and counseling services for the family of the student who died.

Avoiding common mistakes

Vidal (1987) provides a list of twelve mistakes that school systems can make that a little planning and education can prevent. A solid crisis plan would help ensure that things ran smoothly and that none of these possibly fatal mistakes occurred.

Avoid waiting for a crisis before planning. Mistakes are often made during the chaos that occurs after an unanticipated crisis. Anticipate the unfortunate and plan for the future. A crisis plan should be easy to use and understood by all faculty.

Avoid not talking about suicide. Popular myth holds that talk about suicide encourages suicide; however, this myth is false and may create problems in a suicide aftermath. When a suicide occurs, rumors and falsehoods abound and spread like wildfire. If school officials do not actively dispel these rumors, a panic may result and fuel the emotional discord already present.

Avoid preparing students before adults. By preparing the teachers and school administrators first, adults are empowered to stop student confusion and make appropriate referrals.

Avoid showing films and videos about suicide without allowing the students and appropriate opportunity to process the material. An overview and a question and answer session are mandatory here. Also, make sure that the adult presenting the material is knowledgeable about the topic to avoid confusing the students.

Avoid public announcements about the suicide. Public announcements often tend to glorify the suicide and may lead to mass panic and hysteria. Teacher announcements in each classroom can avoid these problems in a more personal atmosphere. Take care that these announcements are handled as soon as possible and at the same time by each teacher. This will avoid the information being passed around from student to student.

Avoid assemblies for announcement purposes or discussion. Information is best given in small groups. Large assemblies tend to breed mass hysteria and some students may see it as a way to get much desired attention. This may actually encourage additional suicides.

Avoid creating lasting memorials in the school, such as a "wall of death." This is often seen as a glorification of the suicide and may encourage further attempts.

Avoid inappropriate and inconsistent dedication pages in school newspapers and yearbooks. Dedication pages should not glorify the suicide nor go into too much detail as to the method of suicide. Also, care should be taken to assure that all dedication pages for different students are similar. Do not allow more space to be given for more popular students, as this may hurt the feelings of the friends of less popular suicide victims.

Avoid funeral services in the schools. It is simply not a good idea to have a funeral at the school. It glorifies the suicide, and the facilities serve as a constant reminder to all.

Avoid telling all to the media. Ensure that all releases are the same. Give general information and focus on what is being done for the survivors. This may help reduce the contagion effect by reducing media glorification of the suicide (Dunne et al., 1992).

Avoid the quick-fix approach. A one-shot visit by a "suicide expert" does not substitute for a well-planned crisis program. Concentrate on school-wide interventions that will block the contagious effect a suicide in the schools often has.

The above guidelines offered by Vidal (1987) appear to be good common sense recommendations for school officials. However, no empirical support for these ideas is offered. In an effort to determine if empirical data support the effectiveness of suicide postvention efforts, the articles which emerged from the above mentioned literature search was examined for the presence of empirical studies of program effectiveness. Only one such study emerged. Postvention efforts were not found to reduce suicide risk indicators

in a treatment group receiving counseling versus a no-treatment control group (Hazell & Lewin, 1993). In this study treatment children were referred for counseling after a student suicide when teachers and counselors identified those students as having been close friends of the child who committed suicide. Controls were then students who were not referred but latter reported that they were in fact friends of the deceased and were overlooked in the referral process. An obvious methodological limitation is a lack of reliable measure of the degree of friendship these students might have shared. It is possible that the teachers referred the closest friends of the deceased and not more distant friends, reducing the comparability of the two groups. Also, there exists no data to suggest that friendship alone is an adequate predictor of grief or suicidal intention following a peer suicide. A further limitation is a lack of base data to which post-suicide data may be compared. Overall, many methodological limitations are present. However, Hazell and Lewin do make a much needed contribution to an area much in need of further research.

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